DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99-010

2. STATE: Illinois

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1999

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905h(1) and 1902(a)(10)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 99 $0.4 million
b. FFY 00 $1.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B, Pages 38, and 39 - Attachment 3.1-A, Pages 13(A), 14 and 15 - Attachment 3.1-B Pages 13(A), 14 and 15

Attachment 4.19-A Page 91(A)
Attachment 3.1-A Pages 17, 17(A), 17(B), 17(C)
Attachment 3.1-B Pages 17, 17(A), 17(B), 17(C)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B, Pages 38, and 39 - Attachment 3.1-A, Pages 13(A), 14 and 15
Attachment 3.1-B, Pages 13(A), 14 and 15
Attachment 3.1-A Pages 17, 17(A), 17(B)
Attachment 3.1-B Pages 17, 17(A), 17(B)

10. SUBJECT OF AMENDMENT:
Alcohol and Substance Abuse Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Ann Patla

13. TYPED NAME:
Ann Patla

14. TITLE:
Director

15. DATE SUBMITTED: 9/29/99

16. RETURN TO:

Illinois Department of Public Aid
201 South Grand Avenue
Springfield, Illinois 62763-0001

ATTN: John Rupcich

[redacted]

#19 Effective Date of Approved Material
7/1/99

Charles Jones 6/6/00

Associate Regional Administrator, Division of
Medicaid and Children's Health

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

07/99 P. Rates for inpatient psychiatric services for individuals under 21 years of age in a hospital setting are described in Chapter VIII A 1. Rates for inpatient psychiatric services for individuals under 21 years of age in a facility other than a hospital are described below:

1. Rates for treatment of alcohol dependency and substance abuse.

a. Rates are determined individually for each participating provider. Upon entry into the program, a provider must submit actual audited costs for one prior fiscal year or projected cost for one fiscal year if the program is new. Those costs are submitted on a completed State of Illinois Consolidated Financial Report (CFR). The costs reported on schedule I of the CFR will be used to determine the facility's rate:

i. Program costs. Reported on lines 1-7, 11-12, 14 and 16; these are primarily the clinical staffing costs, including counseling and paraprofessional staff, therapists, clinicians, and other licensed staff, etc.

ii. Support costs. Reported on lines 18-22, 24 and 25; these include the operating costs of the facility, including room and board related costs, laundry, housekeeping, etc.

iii Capital. Reported on lines 26-34; these are costs of the physical plant and of the facility including rent, depreciation, interest, equipment, etc., and vehicles necessary for the operation of the facility.

b. The calculated reimbursement amount for each of the first three component is the lesser of the facility's reported costs per diem, assuming that it operates at 80 percent capacity, or the maximum established for the component:

i. Program costs. The maximum for comparison is the cost (salary, fringe benefits) per diem of a staffing model that incorporates the following types of staff: counselors, both credentialed and non-credentialed; recreation activity and other specialty staff; a program coordinator; facility coverage staff; a consultant physician; registered nurses, consulting dietitian. Workload assumptions take into consideration programmatic, licensure, and Medicaid certification requirements. In addition, an allowance is made for program supplies and staff training based on the percentage of program supply costs to program staff costs and training tuition from a market-based figure of $400 per eligible FTE per year.

ii. Support costs. The maximum for comparison is 150 percent of the median per diem statewide costs, calculated separately for vehicular-related costs and all other costs.

iii. Capital. The maximum is facility-specific per diem amount from a capital cost model that, based on available research, represents the most appropriate and reliable measures of facility ownership costs. The model incorporates an assumption of space needed, the year of construction and the prevailing financing rate available that year, the minimum useful life of the facility, the cost per square foot for new construction, and factor to adjust for economies of scale. But, in the case of a rented facility, the maximum is 150 percent of the regional median per diem rental costs.

c. The facility rate is the sum of the above components plus an allowance for administrative costs that is 20 percent of the sum of those components.

d. Established rates are increased periodically (no more often than annually), based upon a cost of living increase as appropriated by the Illinois General Assembly.

e. In all cases, the calculated rate is compared to the facility's charge to the general public for the service. The rate paid to the facility is the lesser of the two.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPE OF CARE-BASIS FOR REIMBURSEMENT

Alcoholism and Substance Abuse Treatment:

=7/97 ~~a.~~ ~~Rates are prospective and are established annually for each service. In order that costs can be analyzed for determination of rate, each provider shall submit, upon application for certification, an annual audit for the prior two fiscal years and two copies of the required statistical and financial information on a form specified by the Department. Rates are developed through the application of formal methodologies specific to each category of service. These methodologies are contained in the Department's "Methodologies For the Purchase of Individual Alcohol and Other Drug Abuse Treatment Services (July 1997)" manual.~~

7/99 a. Outpatient care, levels I and II, encompasses two services: individual and group therapy. Each service has an individual statewide rate established. Rates were established years ago based on provider charges to the general public. A single statewide rate specific to individual counseling and a single statewide rate specific to group counseling were established in the early 1990's by applying a simple averaging of all rates accepted across the state. Rates for these services are increased on a periodic basis only(not to exceed annually) with a small percentage cost of living increase as appropriated by the Illinois General Assembly. Reimbursement is payable to the nearest quarter hour. The rates established for the State Fiscal year 2001 are $58.56 per hour for individual counseling and $22.12 for group counseling. In all cases, the established rate shall not exceed the facility's charge to the general public.

=7/97 ~~b.~~ ~~Outpatient (level I, Intensive Outpatient (Level II, Residential Rehabilitation (Level III) and Day Treatment (Level III) rates are considered "all-inclusive", accounting for all reasonable expenses associated with full delivery of a comprehensive array of all clinically necessary and routinely delivered service elements. The rate is calculated as the sum of the following cost components:~~

7/99 b. Outpatient care, level III—Day Treatment and Medically Monitored Detoxification

i. Rates for level III care are determined individually for each participating provider. Upon entry into the program, a provider must submit actual audited costs for one prior fiscal year or projected cost for one fiscal year if the program is new. Those costs are submitted on a completed State of Illinois consolidated financial report (CFR). (The CFR provides a separate column for reporting each program.) The costs reported on schedule I of the CFR for Outpatient Level III services will be used to determine the facility's rate:

A. Program costs. Reported on lines 1-7, 11-12, 14 and 16; these are primarily the clinical staffing costs, including counseling and paraprofessional staff, therapists, clinicians, and other licensed staff, etc.

B. Support costs. Reported on lines 18-22, 24 and 25; these include the operating costs of the facility. (In the case of outpatient services, they exclude including all room and board related costs.)

C. Capital. Reported on lines 26-33; these are costs of the physical plant and of the facility including rent, depreciation, interest, equipment, etc. (In the case of outpatient services, they exclude all room and board related costs based on the exclusion of the square footage of the living/kitchen areas etc.)

ii. The calculated reimbursement amount for each of the first three component is the lesser of the facility's reported costs per diem, assuming that it operates at 70 percent capacity for Medically Monitored Detoxification and 80% for outpatient level III, or the maximum established for the component.

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A. Program costs. The maximum for comparison is the cost (salary, fringe benefits) per diem of a staffing model that incorporates the following types of staff: counselors, both credentialed and non-credentialed; a program coordinator; facility coverage staff; a consultant physician; registered nurses. Workload assumptions take into consideration programmatic, licensure, and Medicaid certification requirements. In addition, an allowance is made for program supplies and staff training.

B. Support costs. The maximum for comparison is 150 percent of the median per diem statewide costs, calculated separately for vehicular-related costs and all other costs.

C. Capital. The maximum is facility-specific per diem amount from a capital cost model that, based on available research, represents the most appropriate and reliable measures of facility ownership costs. The model incorporates an assumption of space needed for the provision of this service, the year of construction and the prevailing financing rate available that year, the minimum useful life of the facility, the cost per square foot for new construction, and factor to adjust for economies of scale. But, in the case of a rented facility, the maximum is 150 percent of the regional median per diem rental costs.

iii. The facility rate is the sum of the above components plus an allowance for administrative costs that is 20 percent of the sum of those components.

Note: Room and board are not covered under this service. Any costs associated with room and board are to be separately reported on the CFR and, to the extent that they may be reimbursed, will be reimbursed entirely at State expense.

iv. Established rates are increased periodically (no more often than annually), based upon a cost of living increase as appropriated by the Illinois General Assembly.

v. In all cases, the calculated rate is compared to the facility's charge to the general public for the service. The rate paid to the facility is the lesser of the two.

~~7/97 c) For Level I and II services, a uniform reimbursement rate is determined based upon normative data comprised of calculated rates for each provider. The median of the individual rates is the basis for the final calculation of the uniform rate. The individual rate for each provider is determined by calculation based upon statewide salary data, staffing and programmatic requirements, workload assumptions, allowances for fringe benefits, clinical training, and program supplies as well as statewide normative data for support, capital and transportation costs.~~

~~=7/97 d) For Level III services, Residential Rehabilitation, and Day Treatment, and Medically Monitored Detoxification, an individual rate is established for each program. A per diem rate is calculated based upon statewide salary data, staffing and programmatic requirements, workload assumptions, allowances for fringe benefits, clinical training, and program supplies as well as statewide normative data for support, specific individual capital component costs, transportation and administrative. Separate calculation models have been established for different bed sizes in order to account for varying economies of scale, beginning at 10 beds and increasing in 5 bed increments. The residential rehabilitation models also distinguish between adult and adolescent programs. The calculated rate for day treatment and Medically Monitored Detoxification excludes domiciliary costs. Payment for Level III services does not include payment of room and board charges.~~

=7/97 c)c) Psychiatric diagnostic services are reimbursed on a per encounter basis to psychiatrists at the practitioner's usual and customary charge, not to exceed the maximum established by the Department of Public Aid.

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13d. REHABILITATIVE SERVICES

1/92 Alcohol and Substance Abuse Services

=7/97 Subacute alcohol and substance abuse treatment services are to be provided in a subacute setting licensed by the Department of Human Services (DHS), Office of Alcoholism and Substance Abuse (OASA), or a hospital licensed by the Department of Public Health; all facilities must be certified for participation by DHS/OASA. All services will be provided by or under the direction of a qualified treatment professional in accordance with a treatment plan approved by a physician. A qualified treatment professional may be an employee of the facility or an independent practioner and must meet at least one of the following minimum requirements set by the Department of Human Services(DHS):

=7/97
- hold clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA);
- be a licensed professional counselor or licensed clinical professional counselor pursuant to the Professional Counselor and Clinical Professional Counselor Licensing Act;
- be a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987;
- be licensed as a psychologist pursuant to the Clinical Psychology Practice Act; or
- be licensed as a social worker or licensed clinical social worker pursuant to the Clinical Social Work and Social Work Practice Act

Alcohol and substance abuse treatment services are limited to the following:

=7/97 ° Outpatient services - Level I care - The provision of ~~diagnostic assessment~~, individual and group counseling ~~and discharge planning services, either individually or in a group~~ on a scheduled or unscheduled basis to an individual who, in the clinical judgement of a qualified treatment professional, is experiencing a problem with alcohol and/or other drugs. These services shall be delivered in accordance with an individual's treatment plan recommended by a physician. Outpatient is a structured program usually offered less than nine hours per week which provides the appropriate hours of service for the level of care required by the client (as set forth in his treatment plan) Treatment must occur in a certified licensed subacute outpatient setting. ~~No more than 25 hours may be reimbursed for an eligible adult client per benefit year.~~ The benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 25 hours per benefit year.

=7/97 ° Intensive Outpatient - Level II care - ~~The provision of diagnostic assessment, counseling and discharge planning services, either individually or in a group on a scheduled only outpatient basis to an individual who, in the clinical judgement of a qualified treatment professional, is experiencing a problem with alcohol and/or drugs.~~ The services for Intensive Outpatient mirror that of Outpatient services Level I identified in Appendix to Attachment 3.1-A Page 13(A)These services shall be delivered in accordance with an individual's treatment plan recommended by a physician. Intensive outpatient is a structured program offered a minimum of nine hours per week which provides the appropriate hours of service for the level of care required by the client (as set forth in his treatment plan) Treatment must occur in a certified licensed subacute outpatient setting. ~~No more than 75 hours of service may be reimbursed for an eligible adult client per benefit year.~~ The benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 75 hours per benefit year.

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~~7/97~~ ~~°~~ ~~Residential Rehabilitation - Level III care - the provision of diagnostic, counseling and discharge planning services, either individually or in a group on an inpatient basis to an individual under age 21 as an EPSDT benefit who, in the clinical judgement of a qualified treatment professional, is experiencing a problem with alcohol and/or other drugs. Services shall be delivered in accordance with the individual's treatment plan recommended by a physician. Residential rehabilitation is a structured program offered seven days a week. This includes a minimum of 25 hours of documented treatment per client per week. Services must occur in a psychiatric facility or in an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Healthcare Organizations.~~

7/97 ° Day Treatment - Level III care - This program includes the following services: individual and group therapy services, case management services relative to discharge planning, registered nurses responsible for providing general nursing care to pregnant or sick substance abusing individuals as well as medication management and administration, nutritional counseling for malnourished substance abusing individuals and the services of the Medical Director as needed. These services shall be delivered in accordance with the individual's treatment plan recommended by a physician. Day Treatment is a structured program offered seven days a week. This includes a minimum of 25 hours of documented treatment per client per week. Such treatment must occur in a subacute residential setting licensed by the Department of Human Services (DHS) and certified as having 16 beds or less. ~~The treatment services are the same as residential rehabilitation services except that the services shall be provided by a program except that the services shall be provided by a program licensed by the Department of Human Services (DHS) and certified as having 16 beds or less. Services shall be delivered in accordance with an individual's treatment plan recommended by a physician. No more than 30 days shall be reimbursed per benefit year for an eligible adult client per benefit year.~~ Reimbursement for this services excludes room and board costs and the benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 30 days per benefit year.

° Medically Monitored Detoxification - Level III care -The service providers mirrors that of the Day Treatment Level III as identified in Appendix to Attachment 3.1-A, page 14. , however, Medically Monitored Detoxification requires a much more intensive medical component. Since individuals are going through withdrawal there is a greater need for nursing care. Additionally, the group sessions are limited to two - three individuals as opposed to upwards of 12 in the Intensive Level III benefit. The treatment is very intense over a three to nine day period as opposed to Intensive Level III care. Reimbursement for this service excludes room and board costs and the benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 9 days per benefit year

10/91 ° Psychiatric diagnostic service - The provision of an evaluation by a psychiatrist and/or examination of a client and exchange of information to determine whether the client's condition is due to the effects of alcohol and/or other drugs or to a diagnosed psychiatric disorder.

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All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process will be provided to individuals under age 21 as an EPSDT benefit and without regard for the established benefit limits for alcohol and substance abuse services.

7/96 Benefit limits will not be applied to a woman who enters treatment during pregnancy and through the end of the month in which the 60-day period following termination of the pregnancy ends (post partum period), or until services are no longer clinically necessary, whichever comes first. This benefit does not apply to a woman who enters treatment services after delivery.

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14c. INTERMEDIATE CARE FACILITY SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES

Preadmission screening is required.

15a. INTERMEDIATE CARE FACILITY SERVICES (OTHER THAN IN AN INSTITUTION FOR MENTAL DISEASE)

A screening assessment is required prior to admission.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

15b. INCLUDING SUCH SERVICES IN A PUBLIC INSTITUTION (OR DISTINCT PART THEREOF)

A screening assessment is required prior to admission.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

16. INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE

All hospital inpatient psychiatric services are subject to a prepayment review. Only medically necessary inpatient psychiatric care will be covered.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

Psychiatric Services for individuals under the age of 21 means inpatient psychiatric services provided in accordance with 42 CFR 441.60 under the direction of a physician by one of the following:

a. a psychiatric hospital
b. an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations
c. a psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities.

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An individual plan of care will be developed for each individual receiving services to improve his/her condition to the extent that inpatient care is no longer necessary. The plan of care must be a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual's situation and reflects the need for inpatient psychiatric care. Development and implementation of the plan will occur no later than 14 days after admission and the plan shall be designed to achieve the recipient's discharge from inpatient status at the earliest possible time. The plan of care will be developed by an interdisciplinary team of personnel who are employed by, or provide services to patients in the facility. Based on education and experience, including competence in child psychiatry, the team must be capable of:

a. Assessing the individual's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities;
b. Setting treatment objectives;
c. Prescribing therapeutic modalities and achieve the plan's objectives

The interdisciplinary team shall consist of one of the following:

a. A board-eligible or board-certified psychiatrist;
b. A clinical psychologist who has a doctoral degree and a physician licensed t practice medicine or osteopathy or
c. A physician licensed to practice medicine or
d. A physician licensed to practice osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

The team must also include one of the following:

a. A psychiatric social worker.
b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.
c. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
d. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.
e. A clinically certified alcohol and drug counselor

In order for the services to be eligible for reimbursement under Medicaid, the team is required to certify:

a. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a Physician; and
c. The services can reasonable be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed,

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17. NURSE-MIDWIFE SERVICES

Nurse-midwife services are a covered service for all eligible clients, provided the care by the nurse-midwife is provided under supervision of a physician and is not in conflict with the Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1987, Ch. 111, par. 3501 et seq.) and implementing regulations.

Nurse-midwife must have completed a program of study and clinical experience for nurse-midwives accredited/approved by the American College of Nurse-Midwives. A nurse-midwife must have and maintain a current agreement with a physician licensed to practice medicine in all its branches who has hospital delivery privileges. A copy of this signed agreement must be on file with the Department.

18. HOSPICE SERVICES

=10/95 Hospice is a covered service for all eligible clients, including residents of intermediate and skilled care facilities, when provided by a Medicare certified hospice provider and in accordance with provisions contained in 42 CFR 418.1 through 418.405.

Covered services include:

- nursing care;
- physician services;
- medical social services;
- short term inpatient care;
- medical appliances, supplies, drugs and biologicals;
- home health aide services;
- occupational therapy, physical therapy and speech-language pathology services to control symptoms; and
- counseling services.

All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process will be provided to EPSDT recipients.

19. CASE MANAGEMENT SERVICES

10/91 Case management is a covered service for eligible children age birth through 20 when provided by qualified case managers to assure treatments which are medically necessary, to correct or lessen health problems detected or suspected by the screening process.

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20. EXTENDED SERVICES TO PREGNANT WOMEN

10/91 The following is a list of major categories of services that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy. There are no limitations applied to these services:

- hospital;
- federally qualified health center (FQHC);
- rural health clinic; and
- physician.

=7/96 Service limits will not be applied to a pregnant woman who is receiving alcohol and substance abuse services. This exemption exists during the pregnancy and through the end of the month in which the 60-day period following termination of the pregnancy ends (post partum period), or until the services are no longer clinically necessary, whichever comes first. These extended limits shall not apply to a woman who enters treatment services after delivery.

23. PEDIATRIC OR FAMILY NURSE PRACTITIONER SERVICES

7/95 Coverage is limited to services provided by a nurse practitioner who has completed a program of study and clinical experience for certified pediatric or certified family nurse practitioner which is accredited and approved by the appropriate Accreditation Board as defined in Department rule. Further, the nurse practitioner must have and maintain a current agreement with a physician licensed to practice medicine in all its branches who has hospital admitting privileges including delivery privileges where applicable.

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13d. REHABILITATIVE SERVICES

1/92 Alcohol and Substance Abuse Services

=7/97 Subacute alcohol and substance abuse treatment services are to be provided in a subacute setting licensed by the Department of Human Services (DHS), Office of Alcoholism and Substance Abuse (OASA), or a hospital licensed by the Department of Public Health; all facilities must be certified for participation by DHS/OASA. All services will be provided by or under the direction of a qualified treatment professional in accordance with a treatment plan approved by a physician. A qualified treatment professional may be an employee of the facility or an independent practioner and must meet at least one of the following minimum requirements set by the Department of Human Services(DHS):

=7/97
- hold clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA);
- be a licensed professional counselor or licensed clinical professional counselor pursuant to the Professional Counselor and Clinical Professional Counselor Licensing Act;
- be a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987;
- be licensed as a psychologist pursuant to the Clinical Psychology Practice Act; or
- be licensed as a social worker or licensed clinical social worker pursuant to the Clinical Social Work and Social Work Practice Act

Alcohol and substance abuse treatment services are limited to the following:

=7/97 ° Outpatient services - Level I care - The provision of ~~diagnostic assessment~~, individual and group counseling ~~and discharge planning services, either individually or in a group~~ on a scheduled or unscheduled basis to an individual who, in the clinical judgement of a qualified treatment professional, is experiencing a problem with alcohol and/or other drugs. These services shall be delivered in accordance with an individual's treatment plan recommended by a physician. Outpatient is a structured program usually offered less than nine hours per week which provides the appropriate hours of service for the level of care required by the client (as set forth in his treatment plan) Treatment must occur in a certified licensed subacute outpatient setting. ~~No more than 25 hours may be reimbursed for an eligible adult client per benefit year.~~ The benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 25 hours per benefit year.

=7/97 ° Intensive Outpatient - Level II care - ~~The provision of diagnostic assessment, counseling and discharge planning services, either individually or in a group on a scheduled-only outpatient basis to an individual who, in the clinical judgement of a qualified treatment professional, is experiencing a problem with alcohol and/or drugs.~~ The services for Intensive Outpatient mirror that of Outpatient services Level I identified in Appendix to Attachment 3.1-A Page 13(A)These services shall be delivered in accordance with an individual's treatment plan recommended by a physician. Intensive outpatient is a structured program offered a minimum of nine hours per week which provides the appropriate hours of service for the level of care required by the client (as set forth in his treatment plan) Treatment must occur in a certified licensed subacute outpatient setting. ~~No more than 75 hours of service may be reimbursed for an eligible adult client per benefit year.~~ The benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 75 hours per benefit year.

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~~7/97~~ ~~°~~ ~~Residential Rehabilitation - Level III care - the provision of diagnostic, counseling and discharge planning services, either individually or in a group on an inpatient basis to an individual under age 21 as an EPSDT benefit who, in the clinical judgement of a qualified treatment professional, is experiencing a problem with alcohol and/or other drugs. Services shall be delivered in accordance with the individual's treatment plan recommended by a physician. Residential rehabilitation is a structured program offered seven days a week. This includes a minimum of 25 hours of documented treatment per client per week. Services must occur in a psychiatric facility or in an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Healthcare Organizations.~~

--7/97 ° Day Treatment - Level III care - This program includes the following services; individual and group therapy services, case management services relative to discharge planning, registered nurses responsible for providing general nursing care to pregnant or sick substance abusing individuals as well as medication management and administration, nutritional counseling for malnourished substance abusing individuals and the services of the Medical Director as needed. These services shall be delivered in accordance with the individual's treatment plan recommended by a physician. Day Treatment is a structured program offered seven days a week. This includes a minimum of 25 hours of documented treatment per client per week. Such treatment must occur in a subacute residential setting licensed by the Department of Human Services (DHS) and certified as having 16 beds or less. ~~The treatment services are the same as residential rehabilitation services except that the services shall be provided by a program except that the services shall be provided by a program licensed by the Department of Human Services (DHS) and certified as having 16 beds or less. Services shall be delivered in accordance with an individual's treatment plan recommended by a physician. No more than 30 days shall be reimbursed per benefit year for an eligible adult client per benefit year.~~ Reimbursement for this services excludes room and board costs and the benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 30 days per benefit year.

° Medically Monitored Detoxification - Level III care -The service providers mirrors that of the Day Treatment Level III as identified in Appendix to Attachment 3.1-A, page 14., however, Medically Monitored Detoxification requires a much more intensive medical component. Since individuals are going through withdrawal there is a greater need for nursing care, Additionally, the group sessions are limited to two - three individuals as opposed to upwards of 12 in the Intensive Level III benefit. The treatment is very intense over a three to nine day period as opposed to Intensive Level III care. Reimbursement for this service excludes room and board costs and the benefit limit for any individual who does not qualify for the EPSDT benefit or who is not pregnant or post-partum is 9 days per benefit year.

10/91 ° Psychiatric diagnostic service - The provision of an evaluation by a psychiatrist and/or examination of a client and exchange of information to determine whether the client's condition is due to the effects of alcohol and/or other drugs or to a diagnosed psychiatric disorder.

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=7/97 All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process will be provided to individuals under age 21 as an EPSDT benefit and without regard for the established benefit limits for alcohol and substance abuse services.

7/96 Benefit limits will not be applied to a woman who enters treatment during pregnancy and through the end of the month in which the 60-day period following termination of the pregnancy ends (post partum period), or until services are no longer clinically necessary, whichever comes first. This benefit does not apply to a woman who enters treatment services after delivery.

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14c. INTERMEDIATE CARE FACILITY SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES

Preadmission screening is required.

15a. INTERMEDIATE CARE FACILITY SERVICES (OTHER THAN IN AN INSTITUTION FOR MENTAL DISEASE)

A screening assessment is required prior to admission.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

15b. INCLUDING SUCH SERVICES IN A PUBLIC INSTITUTION (OR DISTINCT PART THEREOF)

A screening assessment is required prior to admission.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

16. INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE

All hospital inpatient psychiatric services are subject to a prepayment review. Only medically necessary inpatient psychiatric care will be covered.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

Psychiatric Services for individuals under the age of 21 means inpatient psychiatric services provided in accordance with 42 CFR 441.60 under the direction of a physician by one of the following:

a a psychiatric hospital
b an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations
c a psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities.

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An individual plan of care will be developed for each individual receiving services to improve his/her condition to the extent that inpatient care is no longer necessary. The plan of care must be a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual's situation and reflects the need for inpatient psychiatric care. Development and implementation of the plan will occur no later than 14 days after admission and the plan shall be designed to achieve the recipient's discharge from inpatient status at the earliest possible time. The plan of care will be developed by an interdisciplinary team of personnel who are employed by, or provide services to patients in the facility. Based on education and experience, including competence in child psychiatry, the team must be capable of:

a. Assessing the individual's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities;
b. Setting treatment objectives;
c. Prescribing therapeutic modalities and achieve the plan's objectives

The interdisciplinary team shall consist of one of the following:

a. A board-eligible or board-certified psychiatrist:
b. A clinical psychologist who has a doctoral degree and a physician licensed t practice medicine or osteopathy or
c. A physician licensed to practice medicine or
d. A physician licensed to practice osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association,

The team must also include one of the following:

a. A psychiatric social worker.
b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.
c. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
d. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association,
e. A clinically certified alcohol and drug counselor

In order for the services to be eligible for reimbursement under Medicaid, the team is required to certify:

a. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a Physician; and
c. The services can reasonable be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

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17. NURSE-MIDWIFE SERVICES

Nurse-midwife services are a covered service for all eligible clients, provided the care by the nurse-midwife is provided under supervision of a physician and is not in conflict with the Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1987, Ch. 111, par. 3501 et seq.) and implementing regulations.

Nurse-midwife must have completed a program of study and clinical experience for nurse-midwives accredited/approved by the American College of Nurse-Midwives. A nurse-midwife must have and maintain a current agreement with a physician licensed to practice medicine in all its branches who has hospital delivery privileges. A copy of this signed agreement must be on file with the Department.

18. HOSPICE SERVICES

=10/95 Hospice is a covered service for all eligible clients, including residents of intermediate and skilled care facilities, when provided by a Medicare certified hospice provider and in accordance with provisions contained in 42 CFR 418.1 through 418.405.

Covered services include:

- nursing care;
- physician services;
- medical social services;
- short term inpatient care;
- medical appliances, supplies, drugs and biologicals;
- home health aide services;
- occupational therapy, physical therapy and speech-language pathology services to control symptoms; and
- counseling services.

All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process will be provided to EPSDT recipients.

19. CASE MANAGEMENT SERVICES

10/91 Case management is a covered service for eligible children age birth through 20 when provided by qualified case managers to assure treatments which are medically necessary, to correct or lessen health problems detected or suspected by the screening process.

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20. EXTENDED SERVICES TO PREGNANT WOMEN

10/91 The following is a list of major categories of services that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy. There are no limitations applied to these services:

- hospital;
- federally qualified health center (FQHC);
- rural health clinic; and
- physician.

7/96 Service limits will not be applied to a pregnant woman who is receiving alcohol and substance abuse services. This exemption exists during the pregnancy and through the end of the month in which the 60-day period following termination of the pregnancy ends (post partum period), or until the services are no longer clinically necessary, whichever comes first. These extended limits shall not apply to a woman who enters treatment services after delivery.

23. PEDIATRIC OR FAMILY NURSE PRACTITIONER SERVICES

7/95 Coverage is limited to services provided by a nurse practitioner who has completed a program of study and clinical experience for certified pediatric or certified family nurse practitioner which is accredited and approved by the appropriate Accreditation Board as defined in Department rule. Further, the nurse practitioner must have and maintain a current agreement with a physician licensed to practice medicine in all its branches who has hospital admitting privileges including delivery privileges where applicable.